NEWCOMB SUMMER YOUTH PROGRAM
REGISTRATION FORM

TO PARENTS OR GUARDIANS:
Please fill in the following registration form as completely as possible. It is preferred that parents or guardians fill it out. This is not intended to eliminate the participant but to inform the staff for safety purposes. The information will be kept in strictest confidence. Final decision of attendance will be made by the Director or his/her appointed representative.
***Please attach a current photograph for our records.** This can help in case of a lost child.

CHILD'S NAME_____

AGE_____ DATE OF BIRTH_____

PARENT OR GUARDIAN_____

CAREGIVER IF OTHER THAN ABOVE_____

LOCAL ADDRESS _____

MAILING ADDRESS_____

HOME PHONE_____LOCAL PHONE(if different)_____CELL_____

SWIMMING LEVEL PARTICIPANT HAS COMPLETED_____

PLEASE INDICATE IF YOUR CHILD WILL BE RIDING THE BUS: YES NO
Space on the bus is very limited due to social distancing requirements. Parents/Guardian are encouraged to transport to and from camp if possible.

IF YOUR CHILD WILL NOT BE ATTENDING FOR THE WHOLE PROGRAM, PLEASE LIST THE TIME PERIOD THEY WILL BE ATTENDING:
_____

In the event of early dismissal, the name and telephone number of the person responsible for my child in my absence is:
NAME:_____TELEPHONE:_____

This person MUST show identification when picking up child.

****

Please attach a current photo of the above child :

I give permission from picture(s) of my child to be published in print or on line.

Parent signature: _____ Date: _____
MEDICAL RELEASE & INFORMATION

Received _____ Complete Y N

Reviewed by____/____ Copies made Y N

Special instructions:

Please CIRCLE & complete the following.

Has your child had or does he/she now have:

YES	NO	Back Injury/Back problems	YES	NO	Bladder/Kidney Disease
YES	NO	Muscular problems	YES	NO	Skin problems
YES	NO	Head injury	YES	NO	Headaches
YES	NO	Fainting spells	YES	NO	Epilepsy/seizures
YES	NO	Diabetes	YES	NO	Thyroid problems
YES	NO	Ear/Hearing problems	YES	NO	Eye/Vision problems
YES	NO	Chronic cough	YES	NO	Asthma
YES	NO	Heart Trouble	YES	NO	Stomach/Bowel problems
YES	NO	Emotional problems	YES	NO	Psychiatric problems

Explanation of any above information and/or any other chronic condition we should be aware of:

_____

_____

_____

Allergies: □ None □ Food □ Insect □ Seasonal □ Medication □ Life-threatening

Please specify: _____

Medications: (Please list all medications, including Epi-Pens, inhalers, other prescription medication, over-the-counter and nutritional supplements & include the dosage and time given)

_____

_____

*****The medication form on the following page must be completed for any child that absolutely requires any medication during the day or on any out of camp trips (includes Epi pens, inhalers, etc.)***

We/I give the above registered child authorization to attend the Newcomb Summer Youth Program, realizing there is not any medical insurance coverage. We/I hereby agree to assume any and all responsibility and liability in connection with this Program as same pertains to the child listed herein. We/I further agree to save the Town of Newcomb and its employees harmless from any claims and lawsuits in connection with the Program.

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the medical provider selected by the Newcomb Youth program to evaluate, treat and/or hospitalize in an accredited hospital and to X-ray, treat, order injections, anesthesia or surgery for the child.

SIGNATURE OF PARENT/GUARDIAN_____

INSURANCE COMPANY _____

INSURANCE ID#_____GROUP#_____

SUBSCRIBER NAME_____SUBSCRIBER DOB _____

HEALTH PROVIDER_____ PHONE # _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
To be completed by parent & health provider if applicable

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I also acknowledge that if my child is deemed non-self-directed, the administration or any medication is my responsibility. **Please note that only medications that are absolutely necessary during program hours and prescribed by a licensed prescriber are to be administered at camp.**

Signature(Parent or Guardian): _____

Telephone: Home _____Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Camper _____ DOB _____

Diagnosis: _____

<u>Note:</u> NO medications can be administered at camp on an "as needed" basis, including over-the-counter medications, herbals, supplements or prescription medications.

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE :

☐ I deem this child to be **self-directed** and understand that a member of the camp's staff will assist the camper in taking the medication, including field trips.

☐ I deem this child to be **non-self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the parent/guardian.

Prescriber's Signature _____ Date:_____

Address: _____ Phone:_____

☐ Medication must be in original pharmacy labeled container with specific orders and name of medication.

☐ Medication and refills must be brought to camp by parent, guardian or responsible adult.

Sunscreen/Bug Spray:

I give permission for the Town of Newcomb Youth Program to assist my camper, _____, in applying sunscreen and/or bug spray during the hours of participation at the Newcomb Youth Program. **Please note that parents/guardians are responsible for providing the sunscreen and bug spray that they would like their child to use.**

Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____ Date:_____

Newcomb Youth Program
Camper Health Appraisal
(Completed by health care provider)

Name of Camper: _____
Age: _____ **Gender:** _____ **Date of Birth:** _____
Address: _____
Phone #: _____ **Date of Exam:** _____

Immunizations

	Date	Date	Date	Date	Date	Date
DTaP						
DT or Td						
Tdap						
OPV/IPV/eIPV						
HIB						
Hepatitis B						
Varicella						
MMR						
Pneumococcal (PCV 7)						
Pneumococcal (PCV 13)						
Hepatitis A						
Meningococcal ACWY						
COVID 19						
Other:						

Signature of NYS licensed provider (MD, DO, PA, or NP) attesting that above immunization record is accurate: _____ **Title:** _____

Significant Medical/Surgical History:

_____

_____

Allergies: □ None □ Food □ Insect □ Seasonal □ Medication □ Life-Threatening

Specify Allergen(s): _____

Specify previous symptoms: _____ □ History of anaphylaxis

Treatment prescribed: □ None □ Antihistamine □ Epinephrine Autoinjector

MEDICATIONS

Diagnosis	Medication	Dose	Route	Time	Self-directed	Self Admin/Self carry
					□	□
					□	□
					□	□
					□	□
					□	□

This particular form is not mandated.
It is provided by parents' request as a physical form for their physician.

Page 2, physical form

Physical Exam

Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp: _____

Screenings

	Right	Left
Vision without correction		
Vision with correction		
Hearing		

	Normal	**Abnormal**	**Comments**
General Appearance			
Nutrition/Body Mass Index		BMI = WSC % =	
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner – I II III IV V
Musculoskeletal			Scoliosis Y N
Neurological			

This child IS IS NOT qualified to participate in all types of physical activity.
This child IS qualified to participate in only the following type(s) of activity:
Contact/Collision Limited contact Non-contact

This child is qualified to participate in physical activity with the following restrictions:

_____

_____

□ Parent permission & provider consent is required for campers to self-administer & self-carry medication. Campers with this designation are considered independent in taking their medication at camp and require no supervision by a licensed health professional. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Parent will ensure the medication is in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter container/package with child's name on it. To acknowledge acceptance of and compliance with this, please sign below.

Parent signature: _____ Date: _____

I assess this child to be self-directed and may self-carry/self-administer medication. YES NO
(If yes, please complete medication form)

Provider's Name: _____ **Date:** _____

Provider's Signature: _____

Phone #: _____ **Fax #:** _____

Daily COVID-19 Symptom Survey

Name(s):_____

Circle one: Student Staff Visitor

Please answer all questions below: Date: _____, 2021

Temperature greater than 100.4 degrees F Yes No

Symptom	Yes	No
Have you been in close or proximate contact in the past 10 days with anyone who has tested positive through a diagnostic test for COVID 19 or who has or had symptoms of COVID 19?		
Have you tested positive through a diagnostic test for COVID-19 in the past 10 days or been diagnosed by a medical professional with a suspect case of COVID-19 in the past 10 days and are symptomatic?		
Have you traveled within the past 10 days and not complied with requirements of the NYS Travel Advisory?		
Have you experienced any symptoms of COVID-19 in the past 10 days? They include: new cough, chills, shortness of breath, fatigue, body aches, headache, sore throat, nasal congestion/runny nose, new loss of taste or smell, nausea, vomiting, diarrhea.		